Ontario

the Solicitor General — the Chief Coroner

Ministère du Solliciteur général — Bureau du coroner en chef

Verdict of Coroner's Jury / Verdict du jury du corone

(97) 14946

the jury serving on the inquest into the death of: / dûment assermentés, formant le jury dans l'enquête sur le décès de.

Surname / Nom de famille: DOMBROSKIE

Given names / Prénom: ANGELA

aged / âgé(e) de: 8

held at / qui a été menée à: KITCHENER, ONTARIO

~~on the~~ / le: from June 9 until ~~day(s) of~~ / (du/au) July 10 19 97

by / par: DR. K. ACHESON Coroner for Ontario, coroner pour l'Ontario,

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e): ANGELA DOMBROSKIE
2. Date and time of death / Date et heure du décès: JUNE 11, 1996 at 7:55 a.m.
3. Place of death / Lieu du décès: 258 THE COUNTRY WAY KITCHENER, ONTARIO
4. Cause of death / Cause du décès: ASPHYXIA due to Carbon Monoxide poisoning.
5. By what means / Circonstances entourant le décès: ACCIDENT

This verdict was received by me this / Ce verdict a été reçu par moi le 10 day of July 19 97

Kain Acheson

Signature of Coroner / Signature du coroner

Distribution: Original - Regional Coroner for forwarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en ch
Copy - Crown Attorney / Copie - Procureur de la Couronne

CC 010 (Rev. 06/89)

Ontario

the Solicitor General / Ministère du Solliciteur général

the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury / Verdict du jury du coroner

The jury serving on the inquest into the death of: / Jûment assermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille: DOMBROSKIE

Given names / Prénom: DAVID

aged / âgé(e) de: 4

held at / qui a été menée à: KITCHENER, ONTARIO

~~on the~~ / le: from June 9 until / ~~day(s) of~~ (du/au) July 10 19 97

by / par: DR. K. ACHESON Coroner for Ontario, coroner pour l'Ontario,

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e): DAVID DOMBROSKIE
2. Date and time of death / Date et heure du décès: JUNE 11, 1996 at 7:55 a.m.
3. Place of death / Lieu du décès: 258 THE COUNTRY WAY, KITCHENER, ONTARIO
4. Cause of death / Cause du décès: ASPHYXIA due to Carbon Monoxide poisoning
5. By what means / Circonstances entourant le décès: ACCIDENT

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Ontario

the Solicitor General / Ministère du Solliciteur général

the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury / Verdict du jury du coroner

the jury serving on the inquest into the death of: / dûment assermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille: BURNS

Given names / Prénom: JAMIE LEE

aged / âgé(e) de: 4

held at / qui a été menée à: KITCHENER, ONTARIO

~~on the~~ / le: from June 9 until ~~day(s) of~~ / (du/au) July 10 19, 97

by / par: DR. K. ACHESON Coroner for Ontario, coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e): JAMIE LEE BURNS
2. Date and time of death / Date et heure du décès: JUNE 11, 1996 at 7:55 a.m.
3. Place of death / Lieu du décès: 258 THE COUNTRY WAY, KITCHENER, ONTARIO
4. Cause of death / Cause du décès: ASPHYXIA due to Carbon Monoxide poisoning
5. By what means / Circonstances entourant le décès: ACCIDENT

This verdict was received by me this / Ce verdict a été reçu par moi le 10 day of July 19 97

Ken Acheson

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CC 010 (Rev. 06/89)

Ontario

Ministry of the Solicitor General | Office of the Chief Coroner

Ministère du Solliciteur général | Bureau du coroner en chef

Verdict of Coroner's Jury / Verdict du jury du coroner

n jury serving on the inquest into the death of: / dûment assermentés, formant le jury dans l'enquête sur le décès de:

name / Nom de famille: BURNS

Given names / Prénom: DEVIN

held at / qui a été menée à: KITCHENER, ONTARIO

from June 9 until (day(s) of / du/au) July 10 19 97

Coroner for Ontario, / coroner pour l'Ontario, DR. K. ACHESON

ving been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

Name of deceased / Nom du (de la) défunt(e): DEVIN BURNS

Date and time of death / Date et heure du décès: JUNE 11, 1996 at 7:55 a.m.

Place of death / Lieu du décès: 25B THE COUNTRY WAY, KITCHENER, ONTARIO

Cause of death / Cause du décès: ASPHYXIA due to Carbon Monoxide poisoning

By what means / Circonstances entourant le décès: ACCIDENT

his verdict was received by me this 10 day of July 19 97

e verdict a été reçu par moi le

Signature of Coroner / Signature du coroner

Distribution: Original - Regional Coroner for forwarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en chef
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C 010 (Rev. 06/89)

Preface

We have heard testimony for the past four weeks into the tragic deaths of four young children who died by fire in their family home. We have considered the testimony of some 56 participants and reviewed 121 exhibits. The evidence supports the fact that these children were chronically neglected.

The funding and functioning of many critical Child Welfare agencies and services are issues that the jury has had to ponder. We will address these issues in our recommendations.

Despite the involvement of the Children's Aid Society, there was no investigation of the Social Assistance the family was receiving or the budgeting of their finances. Due to this, the inquest lacked information, so we were unable to fully address this matter which we feel contributed to the overall case.

There is a lack of ongoing research targeting Neglect and we feel that a research model should be commissioned. The study results should be widely published across North America so we all can understand the far-reaching effects of this 'social cancer'.

The word NEGLECT is implied in the Child and Family Services Act but it is never defined nor is it sufficiently understood by all child service workers. It leaves persons who must interpret the Act with the task of finding a path in which to pursue neglect. The inherent problem of neglect is that it is diametrically opposed to abuse. While abuse is what is happening to the child, neglect is what is not happening to the child. There is a big difference. Abuse is seen, heard, felt, witnessed and visible. It is a picture as clear as a photograph. Neglect is a Polaroid that has had only a few seconds to develop. It requires time, commitment and the piecing together of much information to formulate a true picture. By its very nature Neglect is pervasive, chronic and reaches far into many lives in our community. It is also debilitating and devastating, surfacing as 'problem children' and 'angry young adults'. It is evident in the misery of children.

In testimony we have heard that 30% of all Children's Aid Society cases involve Neglect. While legislation cannot eradicate Neglect, it is the start of a very long journey. The work being done today sees only a fraction of the cases that are currently in existence. We will need leadership and effective management to continue this work into the future.

The Ministry of Community and Social Services, Children's Aid Societies and other professional agencies are only vehicles to assist in our Child Welfare system. Changes can only occur if the community sets the standards and demands the required and

Recommendations of the Coroner's Jury In The Inquest Into The Deaths of Angela Dombroskie, David Dombroskie, Jamie Lee Burns and Devin Burns

1. *Child Welfare*

A. Child and Family Services Act

Finding: ***The Child and Family Services Act is subject to varied interpretation by Judges, Lawyers, Child Service Workers, School Boards and Health professionals. The Freedom of Information and Protection of Privacy Act and the legislation binding on physicians are at odds with the Child and Family Services Act. The legal ramifications seem to supercede the protection of the child. The Public and professional community appear unaware of the far reaching, devastating and debilitating effects of Neglect on children and its implication in serious injury and death. In this case there was professional awareness of the daily state of child neglect. These professionals were aware of Children's Aid Society involvement, and the assumption was made that the situation was being monitored. As a result, crucial communication with the Children's Aid Society was not on-going.***

1. We recommend that Section 72, subsection 3 of the Child and Family Services Act (Reporting Requirements) be clarified to ensure that professionals and members of the public alike understand those circumstances affecting the protection of children which they are responsible to report to a Children's Aid Society. The Ministry of Community and Social Services should publicize widely the clarified reporting requirements to the public and professionals. The need to continue to report each and every incident irregardless of the involvement of the Children's Aid Society must be strongly emphasized, especially in cases of neglect.

2. We recommend that Section 57 of the Child and Family Services Act be amended to develop strategies/penalties to be imposed by the court upon persons named in a supervision order, where this person in charge of the child has failed to comply with one or more terms of the supervision order.

3. We recommend that Section 37, subsection 2 of the Child and Family Services Act be amended to expand the grounds for finding a child in need of protection so as to include circumstances in which the child's safety, survival, security or development is in danger as a result of:

a) the mental or emotional condition of the person in charge of the child,
b) chronic alcohol or drug abuse by anyone living in the same residence as the child,
c) exposure to family or other violence by or towards the person in charge of the child,
d) chronic neglect or history of neglect

4. We recommend that Part VIII of the Child and Family Services Act - Confidentiality of and Access to Records - be thoroughly reviewed and revised, and then proclaimed into law. Among the revisions, Part VIII to facilitate the sharing of information between the Children's Aid Society and other involved agencies, organizations and professionals where this is necessary to investigate an allegation that a child is in need of protection, or to assess whether the child remains in need of protection. Such disclosure of information be permitted with, or without, the consent of the child's parent, and notwithstanding the provisions of any other legislation.

5. We recommend that the Child and Family Services Act be amended to make it clear that the child's right to have a family is not the same as the parent's right to have a child. The best interests of the child should be the paramount emphasis. The current requirement of 'least restrictive or disruptive course of action that is available....to help a child or family' in Section 1(c) should be modified to the 'least disruptive course of action....to help a child' to avoid any possibility that Section 1(c) be interpreted to confer competing rights on the parents/family.

B. Provincial Standards

Finding: ***There are provincial standards and guidelines for the investigation of abuse, however none exist for the investigation and management of child protection cases including cases of Neglect. We find communication sorely lacking between child welfare agencies and within individual agencies as well. For example in this case, assumptions were made by supervisors that the case manager had spoken to all parties involved when a complaint was made. We also find a lack of accountability within agencies. e.g. lack of file audits in child welfare agencies.***

1. We recommend that the Ministry of Community and Social Services officially recognize the Ontario Association of Children's Aid Societies Accreditation Program as part of its accountability framework in order to promote internal quality assurance in the Child Welfare System, improve self-regulation and improve best practices in the delivery of child welfare services. This could be best facilitated by an outside monitoring agency.

2. We recommend that the Ministry of Community and Social Services in consultation with the Ministry of Education and Training and representatives of Ontario Public and Separate School Boards develop guidelines on a province-wide basis. These guidelines will assist teachers, principals and School Boards to have effective protocols on referrals to a Children's Aid Society in order to improve effectiveness and compliance with the Child and Family Services Act.

3. We recommend that the Ministry of Community and Social Services develop provincial standards/guidelines for the investigation and management of child protection cases. We recommend that these standards for response to child protection address the following issues:

a) It should be made clear to all child welfare agency workers and their supervisors that their client is the child in need of protection not the parent or the family.
b) A child welfare agency worker should be properly trained as an investigator before being assigned to investigate any complaint, whether on a new case or an open file.
c) Complaints should be investigated thoroughly regardless of whether the case is an open file of a family service worker or a new file of an intake worker.
d) Cases should be monitored on an ongoing basis whether or not there are new complaints from the community.
e) Child welfare workers should ACTIVELY seek information from community agencies, for example schools, physicians, family benefits workers, to monitor the protection needs of children.
f) When investigations are made of complaints about a child in need of protection and the child can communicate, the child MUST be interviewed without the parent present.
g) Child welfare workers should be trained in interviewing techniques with very young children.
h) Psycho-Social histories of parents should be part of the investigation in all child protection cases.
i) An investigation into adequate parental supervision should include an inquiry into whether the child(ren) is (are) involved in fireplay behaviour and an assessment of the risk of juvenile fire-setting.
j) Home visits should be made at a time of day when parental supervision is most likely to be lacking, to assess the problem or complaint effectively.
k) In-home interventions for child neglect should be structured, planned and undertaken with clear educational and investigative goals for each intervention.
l) Case aids doing home intervention should have clear instructions about what to watch for, who to talk to, and what to teach. A case aid should report to and be accountable to the case manager for that case.

m) Case notes by an intake or family service worker or case aid should include the date, the time, the length of the visit and whether the visit was scheduled or unscheduled.

n) Records of a case should be organized in such a fashion as to allow RED FLAGGING of all complaints/reports from the community or other professionals.

o) Regular assessments of worker performance should be done by observation of in-home client interactions on an audit basis.

p) Children's Aid Societies should do regular case audits to ensure that policies are being complied with.

q) When terms of voluntary agreements are not followed by a parent, an investigation should be conducted to ensure that the child is not in need of protection by a mandatory supervision order or by apprehension of the child.

r) Documentation given to Family Court about a child in need of protection should contain all relevant information about a case. Documents should be updated to reflect new developments before they are filed with the court, and full disclosure should be given to counsel for the child(ren).

s) Case plans for child welfare workers should state as goals, the outcomes to be achieved, not the means to achieve the goal. For example, attending at a parenting group is a means to the end of learning parenting skills, not the end itself.

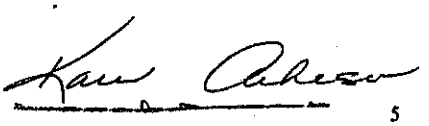
t) Supervisors must provide clinical support and ensure that the front-line workers always remember that their client is the child, not the family.

4. We recommend that the Ministry of Community and Social Services use the standards for response to child abuse as a model for standards for response to child protection and particularly, child neglect.

5. We recommend that the Ministry of Community and Social Services require all Children's Aid Society workers be trained in the skills necessary to investigate and manage child protection cases as outlined in the provincial standards.

6. We recommend that all child welfare workers receive training about the clinical effects of drug abuse and appropriate investigative techniques.

7. We recommend that all child welfare workers receive training about the clinical effects of domestic violence and appropriate investigative techniques.



8. We recommend that the Ministry of Community and Social Services choose a standard Risk Assessment Tool to be used on a mandatory basis by all child welfare agencies in Ontario. This tool should be used by intake and family/child service workers to assist in the identification of risk at the time the file is opened, when a new report or new information is received and as a device for ongoing case assessment. Data from the use of this tool should be collected and analyzed to determine the tool's effectiveness. A shortened version of this tool specifically designed for Intake purposes should be utilized to facilitate quick assessment of the risk factors involved. This could be used to timely assess the need for a court order or apprehension of children.

9. We recommend that the Risk Assessment Tool selected by the Ministry of Community and Social Services include specific inquiry by the child welfare worker into juvenile fire-setting behaviour, particularly in cases of inadequately supervised pre-school children, as well as a structured home safety check where the parent(s) participate(s) with the worker in evaluating the safety (including fire safety) of the home.

10. We recommend to the Ministry of Community and Social Services that they consider sharing appropriate information from its soon to be implemented interactive computer database with Police Services and the Office of the Coroner to assist them in carrying out their respective roles in child protection. We are frustrated with the existing system and levels of documentation. An automated solution should be put in place. This would meet the needs of the front line worker, the needs of the child welfare service delivery system and the needs of the Ministry for systems management.

11. We recommend to the Minister of Community and Social Services that she consider the internal structure of the Ministry and make changes that would ensure a clearer focus on the child protection system and the provision of support to the system. This could be facilitated by reinstating the Office of Director of Child Welfare.

2. *Funding and Resources*

Finding: ***Child Welfare agencies are in need of funding to support the critical component of our society - our children. Supervisors and all Family Services Workers are overloaded and unable to properly function with their current staffing levels. Resources such as intensive and structured intervention programs are almost non-existent. The low level of monitoring received by this particular family appeared to do more harm than good.***

1. We recommend that the Ministry of Community and Social Services in conjunction with the Ontario Association of Children's Aid Societies should develop and implement a funding formula for Children's Aid Societies which recognizes variations in the community's child population, social and economic factors and the workload of the local Children's Aid Society as mandated in Section 15, Subsection 3 of the Child and Family Services Act..

2. We recommend that the Ministry of Community and Social Services in conjunction with the Ontario Association of Children's Aid Societies establish workload standards for the core child protection functions of Intake, Family Services, and services to children in care (including the recruitment and training of foster parents). The standards should state the maximum workload (not number of cases since the amount of work for each case varies) each social worker should manage at any one time, as well as the ratio of social work staff to each supervisor, and to administrative support staff. The standards should recognize the time required to fulfill accompanying training, administrative and accountability functions.

3. We recommend to the Local Children's Aid Societies where workload standards are exceeded, that a formal case be made to the Ministry of Community and Social Services for more funding to increase staff.

4. We recommend to the Ministry of Community and Social Services that requests for more funding to increase staff at the Local Children's Aid Society level be considered based on the workload standards. Should funding be unavailable to cover workload/staff requests, the Ministry should apply to the Ontario Legislature for additional funds.

5. We recommend that the Ministry of Community and Social Services ensure that child welfare agencies are funded to include programs for early intervention and prevention of child protection issues, such as monitoring high risk families (teenage mothers, high risk neighbourhoods)

6. We recommend that the Ministry of Community and Social Services provide funding for the programs which were originally intended to support the present Child and Family Services Act. In particular, studies have shown that chronic neglect needs to be addressed in the context of intensive and structured intervention programs e.g. Family Preservation, and we have received expert evidence to the effect that low level monitoring puts neglected children at greater risk of harm than no intervention at all.

7. We recommend that municipalities should retain some element of fiscal responsibility for child welfare, to maintain some local autonomy and flexibility. As of January 1, 1998 the Ministry of Community and Social Services will 100% fund Children's Aid Societies. We recommend to Regional Councils and municipalities that they continue to contribute funding as they have in the past, with the stipulation that these funds be used for prevention programs specifically aimed at alleviating Neglect.

8. To the Local Children's Aid Societies we recommend that they keep the community aware of any new needs or deficits that arise, so that the community can determine the minimum standard it will tolerate and react accordingly.

9...We recommend to the Ontario Association of Children's Aid Societies and Local Children's Aid Societies the training and use of substitute case workers to alleviate situations of case overload, vacation, illness, leaves of absence and to enable them to meet training requirements. These substitute workers would gain valuable insights into Child Welfare issues and this would also serve as a vehicle for future permanent employment. These resources could be shared among the Provincial societies.

3. *Fire Prevention and Safety*

A. Smoke Detectors

Finding: ***The smoke detector did not work and there was only one in the home. It was on the same circuit as the hall light and the circuit breaker was in the off position. It was never determined if the breaker was tripped by the fire, if the light had something to do with the failure of the circuit or whether it was manually placed into the off position. The landlord and tenant had never tested the smoke detector and the tenant had never been made aware of its location and operating instructions.***

1. We recommend that the Ontario Building Code be revised to stipulate that the power source for the smoke detector be on the same circuit as the refrigerator so that a loss of power would be immediately noted and repaired.

2. We further recommend that the Ontario Fire Code be amended to meet the current Building Code standard as to number and location of smoke detectors. These can be either hard wired or battery operated smoke detectors or a combination.

3. We recommend that the Landlord and Tenant Act require the inspection of smoke detectors in rental dwellings to ensure that they are working properly and review the location and testing mechanisms with all new tenants and certify in writing that such checks have occurred. Written instructions for the maintenance and care of a smoke detector should be posted in every existing rental dwelling unit in a location where such instructions will be readily available.

4. We recommend that the Ontario Fire Code be amended to require written instructions for the maintenance and care of smoke detectors be posted in every rental dwelling unit in a location where such instructions will be readily available.

5. To the Office of the Ontario Fire Marshall we recommend that the public be made aware that the average life expectancy of any smoke detector is 10 years and that these be replaced after this period of time. There should be a date of manufacture stamped on these devices. Batteries for conventional battery units should be changed when the clocks are changed to/from standard and daylight savings time. This should be promoted as a 'Smoke Alarm Test Day'. Promote the availability of different kinds of smoke detectors (ionization, photo-electric, sealed lithium batteries) and their applications and/or advantages.

6. To the Office of the Fire Marshall, Local Fire Departments and Regional Councils we recommend a collaboration to make smoke detectors available and where necessary install smoke detectors free of charge in homes where it is unlikely that one will be installed by any other means.

7. To the Office of the Fire Marshall, we recommend that a battery backup of a single unit hard-wired smoke detectors be considered.

B. Arson Prevention

Finding: ***The Waterloo Region Arson Prevention Program (WRAPP-C) is not well known within the community. It has had only a few referrals from Family and Children's Services and has had no response to its offer to make presentations to interested groups. The WRAPP-C program has been unable to develop an information exchange with the TAPP-C program. The WRAPP-C program differs from the TAPP-C program in the assessment of child fire setters. The research available through the Clarke Institute is funded in part by the Ontario Fire Marshall's Office.***

1. We recommend that the Office of the Ontario Fire Marshall and Local Fire Departments prepare information about this program and make it available to child welfare agencies, children's mental health providers, teachers, fire and police services and other members of the community.

2. We recommend that child welfare professionals receive training regarding the links between preschool fire-setting behaviour and child protection issues.

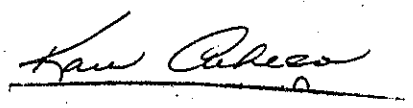
3. We recommend that the Ministry of Community and Social Services, the Ontario Association of Children's Aid Societies and Children's Aid agencies also develop links with the WRAPP-C/TAPP-C programs.

4. We recommend to the Office of the Ontario Fire Marshall and the Solicitor General that they encourage the exchange of information between the TAPP-C and WRAPP-C programs.

5. We recommend that child fire-setters be interviewed for assessment screening by a children's mental health professional. A home safety check should be immediately provided for every case upon referral.

6. We recommend that the federal Hazardous Products legislation be amended to:
   a) prohibit the sale, distribution or giving away of any ignition devices to persons under the age of eighteen
   b) to require that ignition devices be kept behind the counter in retail stores
   c) no minor may possess an ignition device unless the minor is under the supervision of an adult
   d) require that child-resistant lighters be designed so that the lighter is rendered inoperable if the safety mechanism is removed
   e) increase the visibility of warnings on disposable lighters (Larger print)

7. We recommend that the Office of the Ontario Fire Marshall and other private sector entities such as insurance companies provide funding to ensure that Levels 2 through 4 of the 'Learn Not To Burn' program become available to all Canadian schools.



4. Emergency Services

Finding: ***The police were the first service dispatched when the nature of the emergency was as yet unknown. The discrepancy in time between the police and fire services caused some confusion when analyzing response times after the fact.***

1. To the Local 911 Dispatch Centre, the Regional Ambulance Services, the Police Services Board and the Office of the Ontario Fire Marshall we recommend that if there is not an immediate request for a specific emergency service that all services be dispatched.

2. To the Regional Police Services, the Local Fire Departments and the Regional Ambulance Services we recommend that they synchronize their clocks on a regular basis.

5. Education

Finding: ***We find that with this particular family a role model to demonstrate appropriate life skills was unavailable. There was a need for essential parenting skills. Due to lack of supervision the children's safety was jeopardized. When it comes to safety matters and life skills, our education system remains as one of our most essential resources. In this case it was the only one.***

1. We recommend to the Ministry of Education and Training that they provide appropriate funding and make it clear that schools should continue to teach students parenting and life skills in appropriate grade levels (senior elementary/junior secondary).

2. We recommend that the new curriculum from the Ministry of Education continue to require safety education with specific outcome expectations at grades 3, 6, and 9. The outcome specified for the end of grade 3 should specify how to 'get out alive', and the dangers of playing with fire in the fire safety outcome exceptions. Teachers should make use of available tools such as the 'Learn Not to Burn' program.

3. We recommend that the Universities of Ontario which provide degrees in Social Work at the Bachelor and Master's levels foster a stronger research culture in child welfare programs and that continuing education programs utilizing research results be offered to social workers in present practice. We also suggest that courses be taught in investigative techniques, Neglect: Causes and Effects, substance abuse, domestic violence and the interviewing techniques of very young children.

4. We recommend to the Ministry of Community and Social Services that they consider launching a public awareness campaign on Neglect to highlight the effects on children and the community. This should use all forms of the media. Public service announcements should be broadcast at a time when the target audience will be most likely to benefit.

5. We recommend to Health Canada that they re-establish their public awareness campaign concerning child-resistant lighters (Out of Sight, Out of Reach).

Karen Anderson

Coroner's Explanation
of the Verdict of the Jury at the Inquest
into the Deaths of Angela and David Dombroskie
and Jamie Lee and Devin Burns

Dates of Inquest : June 9 - July 10,1997.
Presiding Coroner: Dr. Karen Acheson
Crown Attorney: Assistant Crown Attorney Ms. Dorothee Retterath
Investigating Officer: Detective Gary Haffner, Waterloo Regional Police
Coroner's Constable: Constable Roland Pike, Waterloo Regional Police

This verdict explanation contains a brief synopsis of the evidence presented at this inquest together with some explanatory remarks about the individual recommendations made by the jury. The sole purpose of this explanation is to assist the reader to understand the jury's recommendations, it is not intended to replace the verdict. I would like to stress that this explanation is my interpretation of the evidence and the jury's reasons.

Synopsis

On the early morning of June 11,1996, a neighbour saw Jamie Lee and Devin, the two youngest children (ages 3 and 4) of the Dombroskie/Burns household in their back yard without any apparent parental supervision. A short time later, the house was seen to be on fire. According to the Dombroskie mother's testimony, she was wakened at approximately 7:30 a.m. by her son, David,(also aged four) who told her there was a fire. She smelled smoke and went downstairs to discover a fire on the couch in the living room. She thought the children were all asleep in their beds except David. She did not check on their whereabouts before going downstairs to check on the fire. She did not take David with her.

Whe she saw the fire she thought it wasn't too bad and she went to the kitchen to phone 911. She opened the rear sliding door while the phone was ringing because it was hard to breathe in the smoke. Once the door was open, the fire spread quickly. She was standing in the open doorway screaming when she was pulled from the house by a passerby. The first people on the scene were told that four children were still in the house but the fire was too far advanced to permit rescue attempts. All four children were found dead in the front bedroom located above the living room.

The four children had the same mother and the youngest two had the same father and had his name. The parents were not living together at the time of the fire.

David Dombroskie was nearly five years old at the time of the fire. His parents knew that David had played with matches/lighters and fire in the past. His mother was a smoker who regularly left her cigarettes and lighter on the coffee table in front of the couch in

the living room and testified that they were in that location when she went to bed the night before the fire. This knowledge led the mother to conclude that David started the fire accidentally while playing with her lighter or matches.

Neighbours and parents of a friend of Angela also testified that David played with lighters and matches. The investigator for the Office of the Fire Marshal conducted an investigation and concluded that the fire was caused by "open flame to combustible" and was consistent with a fire caused by a child playing with matches or a lighter.

The children were subjects of an open file with Family and Children's Services of Waterloo Region. The file was opened in 1994 when an anonymous caller alleged that the children were living in conditions of filth with babies crawling on floors covered with dirt and garbage and dog excrement, their food supply was poor and their parents used crack cocaine. With the exception of the crack cocaine which was not investigated, the intake worker found conditions to be as described and the children were placed under a mandatory supervision order by the court (on consent). The order was for six months and was extended once.

The mandatory supervision order was terminated by the court on the recommendation of the case manager who found improvement in the cleanliness of the home and the food supply. The case manager did not inform the court that reports had been received by F&CS about significant inadequate parental supervision. The only investigation of these reports was to ask the mother if they were true. When she denied them, the investigation was concluded.

The mandatory supervision order was replaced with a voluntary agreement that specified that the mother and her children would attend various groups for counseling and socialization. The only one who did attend group was Angela, age 8 who went to group on Thursdays after school. Because the voluntary agreement was not followed by the mother, ongoing involvement with the case worker and case aid was reduced considerably. The file was left open because there continued to be reports from the school and the community about the inadequate or no supervision of the children and lack of clothing etc.

On May 16, 1996, the police were called when baby Devin (age 3) was found wandering alone on a busy roadway wearing only a diaper. The passerby who found him met a neighbour of the family who said she knew where he belonged and the two of them knocked on the front door and the rear sliding door without getting any response. They checked these two doors and found them locked.

The police officer who responded to this call found the mother coming out the front door when he arrived. She admitted that she needed help with raising four children alone and would accept help from the F&CS. He spent some time talking to her and searching the house with her permission because he was concerned that she was under the influence of drugs. He found no evidence of drugs and despite a discussion with his sergeant, he could find no legal grounds for apprehending the children. Angela was not at home at the time and David was returned home by a teacher when the police officer was there

because his mother had forgotten to pick him up. This was a common occurrence because the mother was supposed to pick David, age 4, up from school on Thursdays when Angela was at group and she usually forgot.

The officer reported his concerns to F&CS by voice mail that evening and followed up with a phone report to intake the following day. The report had not been investigated by the time of the fire, some 26 days later.

There were four applications for standing and all were granted. Family and Children's' Services of Waterloo Region were granted standing and represented by Mr. Hamill. The Kitchener Fire Department was granted standing and represented by Ms. Arnold. The Waterloo County Public School Board and the Waterloo County Separate School Board were granted standing and were represented by Mr. Gleave and Mr. Earl respectively.

There was a lot of community concern about these deaths. The inquest was called at the request of the citizens of Kitchener when the coroner received a letter from the City Clerk containing a motion from City Council that an inquest be requested into the circumstances surrounding the deaths of these children.

The jury's answers to the five questions about each deceased child are self explanatory. The jury wrote reasons with their recommendations which they entitled "Findings". They began their recommendations with a preface:

<u>Preface</u>

We have heard testimony for the past four weeks into the tragic deaths of four young children who died by fire in their family home. We have considered the testimony of some 56 participants and reviewed 121 exhibits. The evidence supports the fact that these children were chronically neglected.

The funding and functioning of many critical Child Welfare agencies and services are issues that the jury has had to ponder. We will address these issues in our recommendations.

Despite the involvement of the Children's Aid Society, there was no investigation of the Social Assistance the family was receiving or the budgeting of their finances. Due to this, the inquest lacked information, so we were unable to fully address this matter which we feel contributed to the overall case.

There is a lack of ongoing research targeting Neglect and we feel that a research model should be commissioned. The study results should be widely published across North America so we all can understand the far-reaching effects of this 'social cancer'.

The word NEGLECT is implied in the Child and Family Services Act but it is never defined nor is it sufficiently understood by <u>all</u> child service workers. It leaves persons who must interpret the Act with the task of finding a path in which to

pursue neglect. The inherent problem of neglect is that it is diametrically opposed to abuse. While abuse is what is happening to the child, neglect is what is not happening to the child. There is a big difference. Abuse is seen, heard, felt, witnessed and visible. It is a picture as clear as a photograph. Neglect is a Polaroid that has had only a few seconds to develop. It requires time, commitment and the piecing together of much information to formulate a true picture. By its very nature Neglect is pervasive, chronic and reaches far into many lives in our community. It is also debilitating and devastating, surfacing as 'problem children' and 'angry young adults'. It is evident in the misery of children.

In testimony we have heard that 30% of all Children's Aid Society cases involve Neglect. While legislation cannot eradicate Neglect, it is the start of a very long journey. The work being done today sees only a fraction of the cases that are currently in existence. We will need leadership and effective management to continue this work into the future.

The Ministry of Community and Social Services, Children's Aid Societies and other professional agencies are only vehicles to assist in our Child Welfare system. Changes can only occur if the community sets the standards and demands the required and appropriate funding.

The jury's frustration at not being able to fully evaluate the financial circumstances of the Dombroskie/Burns family flows from the lack of reliable evidence about this important matter. The father testified that when he lived with the family, he had no means of support and got money from her to buy crack cocaine. He was charged with assault (on the mother) and went to jail for a period of time during the mandatory supervision period. When they found no food in the cupboards, the mother told F&CS (Family and Children's Services) workers that she loaned several hundred dollars to a friend.

The obvious poverty of the family was compounded by the mother's inability to budget and the misuse of her limited financial resources by at least one of her male partners. There was no apparent attempt by F&CS to deal with this financial mismanagement although it was clearly a source of some of the children's difficulties.

Throughout this verdict, the terms Children's Aid Society (CAS) and Family and Children's Services (F&CS) are used interchangeably. There was testimony at the inquest that all Children's Aid Societies are incorporated under the title "Children's Aid Society" but some of the societies have adopted the name Family and Children's Services.

Recommendations of the Coroner's Jury In The Inquest Into The Deaths of Angela Dombroskie, David Dombroskie, Jamie Lee Burns and Devin Burns

1. Child Welfare

A. Child and Family Services Act

Finding: ***The Child and Family Services Act is subject to varied interpretation by Judges, Lawyers, Child Service Workers, School Boards and Health professionals. The Freedom of Information and Protection of Privacy Act and the legislation binding on physicians are at odds with the Child and Family Services Act. The legal ramifications seem to supersede the protection of the child. The Public and professional community appear unaware of the far reaching, devastating and debilitating effects of Neglect on children and its implication in serious injury and death. In this case there was professional awareness of the daily state of child neglect. These professionals were aware of Children's Aid Society involvement, and the assumption was made that the situation was being monitored. As a result, crucial communication with the Children's Aid Society was not on-going.***

1. We recommend that Section 72, subsection 3 of the Child and Family Services Act (Reporting Requirements) be clarified to ensure that professionals and members of the public alike understand those circumstances affecting the protection of children which they are responsible to report to a Children's Aid Society. The Ministry of Community and Social Services should publicize widely the clarified reporting requirements to the public and professionals. The need to continue to report each and every incident regardless of the involvement of the Children's Aid Society must be strongly emphasized, especially in cases of neglect.

Evidence was heard at the inquest that the Child and Family Services Act requires the public to report a child in need of protection but does not provide a penalty if this report is not made. The Act requires certain professionals (including teachers) to report a child in need of protection if physical, sexual, emotional harm has been done or treatment for physical or mental illness is not provided. It includes penalties if these cases are not reported. The instances of a child in need of protection with penalties for non reporting can broadly be described as instances of abuse which has already occurred (even though the word abuse is not found in the Act).

Teachers and principals from the public and separate school systems testified that the professionals' duty to report was limited to the instances of abuse that had penalties for not reporting. They expressed concern that they would be sued if they reported any other instances of a child in need of protection. In fact, the teachers and other professionals have the same duty to report as any member of the public but will only be penalized if they do not report instances of abuse that has already occurred. This misunderstanding of the professional's duty to report a child in need of protection has led to this recommendation.

2. We recommend that Section 57 of the Child and Family Services Act be amended to develop strategies/penalties to be imposed by the court upon persons named in a supervision order, where this person in charge of the child has failed to comply with one or more terms of the supervision order.

The jury heard evidence that the parents failed to comply with a substantial number of the provisions of the original mandatory supervision order in the fall of 1994, even though the order was obtained on consent. F&CS workers testified that they felt powerless to do anything about this non compliance except apply for extension of mandatory supervision.

Evidence was clear that apprehension of the children was a powerful incentive for the mother to cooperate and that the threat of loss of her children resulted in some compliance with F&CS in the summer of 1994. The power of this incentive was recognized and used effectively by the original intake worker and the original summer student who worked as case worker over the summer.

There was testimony that non compliance with supervision orders is a common problem for which workers have no training and know of no recommended strategies.

3. We recommend that Section 37, subsection 2 of the Child and Family Services Act be amended to expand the grounds for finding a child in need of protection so as to include circumstances in which the child's safety, survival, security or development is in danger as a result of:

- **a)** the mental or emotional condition of the person in charge of the child,
- **b)** chronic alcohol or drug abuse by anyone living in the same residence as the child,
- **c)** exposure to family or other violence by or towards the person in charge of the child,
- **d)** chronic neglect or history of neglect

Evidence was heard at the inquest that the mother had a psychiatric illness which was severe enough to affect her ability to supervise her children.

The father testified that he used crack cocaine while living with the family and that he bought the crack with the family's social assistance money.

The father assaulted the mother on several occasions and was found guilty of assault and jailed.

Evidence of school teachers and neighbours about the children's lack of clothing suitable for the weather, their hunger, and their lack of supervision was compelling and consistent.

4. We recommend that Part VIII of the Child and Family Services Act - Confidentiality of and Access to Records - be thoroughly reviewed and revised, and then proclaimed into law. Among the revisions, Part VIII to facilitate the sharing of information between the

Children's Aid Society and other involved agencies, organizations and professionals where this is necessary to investigate an allegation that a child is in need of protection, or to assess whether the child remains in need of protection. Such disclosure of information be permitted with, or without, the consent of the child's parent, and notwithstanding the provisions of any other legislation.

Angela and David's teachers and principals were aware that the Children's Aid was involved in their lives. Nevertheless they had daily evidence that things were not improving. (e.g. They were hungry in the morning, their clothing was dirty, ill fitting, had holes (i.e. David wore track pants that exposed his genitals) and was not warm enough for the season (an especially serious concern in the winter when the children came to school without boots, mitts, and sometimes without coats) and David, aged four was not picked up from school on Thursdays when Angela was at group) They did not report lack of improvement to the CAS because they felt that the CAS already knew about the children's problems and they had concerns about what information was confidential and could only be revealed if the CAS workers requested it as part of an investigation.

5. We recommend that the Child and Family Services Act be amended to make it clear that the child's right to have a family is not the same as the parent's right to have a child. The best interests of the child should be the paramount emphasis. The current requirement of 'least restrictive or disruptive course of action that is available....to help a child or family' in Section 1(c) should be modified to the 'least disruptive course of action....to help a child' to avoid any possibility that Section 1(c) be interpreted to confer competing rights on the parents/family.

Apart from the Intake Worker who first investigated the reports of neglect, testimony from the case aid workers, group leaders, case managers and supervisors of F&CS revealed a strong bias toward maintaining the integrity of the family at all costs. It was apparent that in endeavouring to help the children, the workers tried to form relationships with the mother. These attempts to form a relationship undermined the workers' ability to perform their function as monitors and investigators for fear of alienating her.

When asked who the client was, these workers said the family was the client. It became obvious at the inquest that the legislation requiring the least intrusive course of action to help a child or family was interpreted by the CAS as conferring rights on the parent which competed with the rights of the child.

B. Provincial Standards

Finding: ***There are provincial standards and guidelines for the investigation of abuse, however none exist for the investigation and management of child protection cases including cases of Neglect. We find communication sorely lacking between child welfare agencies and within individual agencies as well. For example in this case, assumptions were made by supervisors that the case manager had spoken to all parties involved when a complaint was made. We also find a lack of accountability within agencies. e.g. lack of file audits in child welfare agencies.***

1. We recommend that the Ministry of Community and Social Services officially recognize the Ontario Association of Children's Aid Societies Accreditation Program as part of its accountability framework in order to promote internal quality assurance in the Child Welfare System, improve self-regulation and improve best practices in the delivery of child welfare services. This could be best facilitated by an outside monitoring agency.

See jury's Finding.

2. We recommend that the Ministry of Community and Social Services in consultation with the Ministry of Education and Training and representatives of Ontario Public and Separate School Boards develop guidelines on a province-wide basis. These guidelines will assist teachers, principals and School Boards to have effective protocols on referrals to a Children's Aid Society in order to improve effectiveness and compliance with the Child and Family Services Act.

The jury heard evidence that the two school boards in Waterloo Region have developed their own guidelines for teachers about their duty to report. When the guidelines or protocols were examined that the protocols were really quite different and one protocol required any reporting to be done through school officials. The other protocol clearly stated that the duty to report rested with the teacher who found evidence of abuse. Neither of these protocols clarified the facts that professionals' duty to report abuse is associated with a penalty if not complied with, and professionals have a duty to report that is the same as the community duty for all other instances of a child in need of protection.

3. We recommend that the Ministry of Community and Social Services develop provincial standards/guidelines for the investigation and management of child protection cases. We recommend that these standards for response to child protection address the following issues:

a) It should be made clear to all child welfare agency workers and their supervisors that their client is the child in need of protection not the parent or the family.
b) A child welfare agency worker should be properly trained as an investigator before being assigned to investigate any complaint, whether on a new case or an open file.
c) Complaints should be investigated thoroughly regardless of whether the case is an open file of a family service worker or a new file of an intake worker.
d) Cases should be monitored on an ongoing basis whether or not there are new complaints from the community.
e) Child welfare workers should ACTIVELY seek information from community agencies, for example schools, physicians, family benefits workers, to monitor the protection needs of children.
f) When investigations are made of complaints about a child in need of protection and the child can communicate, the child MUST be interviewed without the parent present.

g) Child welfare workers should be trained in interviewing techniques with very young children.

h) Psycho-Social histories of parents should be part of the investigation in all child protection cases.

i) An investigation into adequate parental supervision should include an inquiry into whether the child(ren) is (are) involved in fireplay behaviour and an assessment of the risk of juvenile fire-setting.

j) Home visits should be made at a time of day when parental supervision is most likely to be lacking, to assess the problem or complaint effectively.

k) In-home interventions for child neglect should be structured, planned and undertaken with clear educational and investigative goals for each intervention.

l) Case aids doing home intervention should have clear instructions about what to watch for, who to talk to, and what to teach. A case aid should report to and be accountable to the case manager for that case.

m) Case notes by an intake or family service worker or case aid should include the date, the time, the length of the visit and whether the visit was scheduled or unscheduled.

n) Records of a case should be organized in such a fashion as to allow RED FLAGGING of all complaints/reports from the community or other professionals.

o) Regular assessments of worker performance should be done by observation of in-home client interactions on an audit basis.

p) Children's Aid Societies should do regular case audits to ensure that policies are being complied with.

q) When terms of voluntary agreements are not followed by a parent, an investigation should be conducted to ensure that the child is not in need of protection by a mandatory supervision order or by apprehension of the child.

r) Documentation given to Family Court about a child in need of protection should contain all relevant information about a case. Documents should be updated to reflect new developments before they are filed with the court, and full disclosure should be given to counsel for the child(ren).

s) Case plans for child welfare workers should state as goals, the outcomes to be achieved, not the means to achieve the goal. For example, attending at a parenting group is a means to the end of learning parenting skills, not the end itself.

t) Supervisors must provide clinical support and ensure that the front-line workers always remember that their client is the child, not the family.

The evidence about the protection needs of these four Dombroskie children revealed a number of problem areas. The jury recommendation that provincial standards/guidelines be developed for investigation and management of child protection issues includes detailed recommendations about the issues the standards should address. These issues are areas that the jury found to be problems in the CAS investigation and management of the Dombroskie/Burns case.

a) *Children's Aid workers testified that they thought their client was the family. The emphasis on the family as client set up a competing interest that hampered the workers ability to see the child protection issue clearly. The case manager, the case aides and the group readers did not have training as investigators. When they received information or community or professional complaints about the Dombroskie/Burns children, they routinely asked the mother about the complaint. She routinely denied that anything was a problem. At no time did any of these workers interview the eldest child or the complainants or anybody else who may have been able to confirm the complaint or confirm that there was no need to be concerned.*

b) *The intake worker who first opened the file of the Dombroskie/Burns children investigated the complaint thoroughly. This was the last time that any complaint from the community or from professionals was ever investigated thoroughly. Once a file was opened, complaints investigations were limited to asking the children's mother, whether the incidents being complained about actually occurred. She routinely denied the occurrence of such problems.*

c) *The case evaluation was handled in a disorganized manner. The case manager and case aide looked very hard for any signs of improvement and did not look very hard for any signs of ongoing problems. Proper investigation i.e. checking with the eldest child in the family, checking with neighbours, checking with the school, would have told them immediately that there was no significant improvement.*

d) *This recommendation speaks to the comments made in part (d) above.*

e) *This recommendation speaks to the issue explained in part (d) above.*

f) *This recommendation speaks at the explanation in part (d) above. Angela, at age 7/8, was old enough to talk to an interviewer. David, at age 4, Devin and Jamie-Lee, might have been interviewed if the child's welfare workers had any training in interviewing young children.*

g) *A psycho-social history of the mother was never taken as part of this case investigation. It is notable that she was found later to suffer from significant depression. The father of the two youngest children was a crack user and there are allegations that the mother also used crack which have never been substantiated or investigated properly. There was also evidence at the inquest that there was a history of psychiatric disorder and unspecified family problems in the mother's family. This information should have been taken so as to assist the court and the workers in assessing the true problems faced by the parents and in designing programs to ameliorate the problems.*

h) *Testimony from a child psychiatrist and expert in juvenile fire-setting behaviour revealed that pre-school fire-setters are often found to have a history of inadequate parental supervision. This information was clearly not known to the children's aid workers or to the expert in social work who testified at the inquest. Since fire-play behaviour is such a risky behaviour and the outcome may be death for the child*

involved in fire-play as well as other family members and other persons, it is imperative that whenever the children's aid conducts an investigation into adequate/inadequate parental supervision they inquire into fire-play behaviour and set up a way of assessing the risk of juvenile fire-setting.

i) Many of the complaints received by the Children's Aid Society and the observations actually made by the case aide worker and the case manager revealed that parental supervision was quite inadequate in this family in the early morning hours. However, the case aide worker and the case manager never visited the home before eleven o'clock in the morning. It is notable that the fire that killed everybody was set between seven and seven thirty in the morning. One might postulate that a program which assisted the mother to understand the serious risk implicit in fire-play behaviour and to understand the importance of early morning parental supervision may have been lifesaving.

j) The Children's Aid Society devoted significant resources to in-home visits at the Dombroskie/Burns family home while the case was under mandatory supervision. However, these visits were invariably short and limited to a quick inspection of cupboards for food and the rooms for cleanliness. There were no structured or planned in-home interventions to assist Leanne identify her problems with parenting and to assist her in improving these.

Testimony by an expert in social work described a family protection program in which workers coming to do in-home interventions have a structured and planful approach to the intervention and are really aware of their obligations with respect to teaching, monitoring and investigating with each visit.

m) Case notes taken by intake and family services workers in this case were often lacking the date, the time, the length of the visit and whether the visit was scheduled or unscheduled. This made it very difficult to evaluate how significant the intervention was and whether the intervention actually addressed the issues the family was having difficulty with.

n) Records of community and professional complaints about children in need of protection in this case were not well identified and both the expert and social worker who reviewed the file found it very difficult to find these complaints. This recommendation suggests that all complaints and reports from community and professional sources be red-flagged in some way so that it is apparent to the case manager and case aides that problems continue.

o) It was also apparent that early reports about problems with food supply and cleanliness and drugs were eclipsed by later complaints about significantly inadequate parental supervision. However, neither the case manager nor the case aide worker changed their approach to this family or appeared to recognize that a significantly more serious problem was being reported. This may very well have been because these complaints were lost in a pile of paper.

p) The social work expert was quite critical of the in-home client interaction by the case aide and case manager and recommended that an audit be performed to ensure that in-home interventions were observed to maximize their effectiveness on a regular basis.

q) The Children's Aid Society in Waterloo Region has policies about the management and investigation of cases which were not followed in this case. Regular case audits would ensure that policies are complied with.

r) The evidence revealed that after the mandatory supervision period, a voluntary agreement was entered into with the mother to assist in the protection of her children. The terms of the voluntary agreement were not followed at all and the reaction of the Children's Aid Society to this non-compliance was to put the case "on the back burner" despite the fact that complaints continued to arrive from the schools and the neighbours about inadequate parental supervision and neglect of clothing and food. The jury is recommending that when a voluntary agreement is not met a comprehensive investigation be undertaken to ensure that the child is not still in need of protection and stronger measures than voluntary agreements will be required.

s) When the mandatory supervision order was terminated the documentation given to the court indicated that improvements had occurred. This was despite the fact that there were two complaints prior to the court case about serious instances of inadequate parental supervision. The court papers were prepared in June of 1995 and the court case was heard in late August. The case was heard somewhat later than expected because of adjournments. Nevertheless, the case manager who knew about the complaints never appended any additional information to the court documents to let the court know that there were additional concerns expressed by the community and by the police. The court therefore made a decision about terminating mandatory supervision without having all the relevant information.

t) Group leaders, case aide workers and the case manager continually identified attendance at parenting groups as a goal for the mother. It was apparent from all records about the group she did attend, however, that she never saw herself as having difficulty with parenting. CAS workers need to recognize that the goal was to improve her parenting, not to improve her attendance at groups. All of the workers agreed that by the time the case was nearing the time of the deaths of the children they were coming to the conclusion that group may not be the best way to reach her and convince her about her parenting problems. This situation may have been significantly improved if the workers' goals had been the outcome (i.e. the improvement of the mother's parenting), rather than the means (i.e. attendance at groups).

u) The supervisor of this file who was very busy considered that the case manager was a very experienced case manager and though she did get some updates about the case, was not involved in reviewing the actions being taken or the response to complaints.

4. We recommend that the Ministry of Community and Social Services use the standards for response to child abuse as a model for standards for response to child protection and particularly, child neglect.

Evidence was given at the inquest that the standards for response to child abuse that were written by the Ministry of Community and Social Services were useful standards which assisted the Children's Aid Societies in setting up programs to respond to child abuse. These standards for response to child abuse could be used as a template or model when the ministry writes standards for response to child protection issues in particular child neglect.

5. We recommend that the Ministry of Community and Social Services require all Children's Aid Society workers be trained in the skills necessary to investigate and manage child protection cases as outlined in the provincial standards.

It was clear throughout this case that the Children's Aid Society workers did not have the skills necessary to investigate the case of children in need of protection and further did not have the skills necessary to manage the case - they had no clear idea of the outcome or goal they were looking for and the means necessary to achieve it. It was apparent throughout the inquest that training is urgently required in the investigation and management skills so that when standards are written for all child protection cases that Children's Aid Society workers are trained sufficiently in the skills of investigation and management.

6. We recommend that all child welfare workers receive training about the clinical effects of drug abuse and appropriate investigative techniques.

There were allegations in the reports of the community about the drug taking behaviour of the parents. There were also multiple episodes where workers and the police noted that the mother was extremely drowsy and "out of it". None of the child care workers had any training about the critical effects of drug abuse and they had no idea how to undertake an investigation of drug abuse. This is an important area because it was clear that a parent under the influence of drugs would certainly be a poor caretaker for four children under the age of seven/eight.

7. We recommend that all child welfare workers receive training about the clinical effects of domestic violence and appropriate investigative techniques.

It was clear from the evidence that the father assaulted the mother and he went to jail for such assault. There is every likelihood that this assault took place in the sight and hearing of the children but at no time did the case aide workers evaluate, investigate or interview these children, neighbours or other professionals to assess the clinical affects of this violence on the children.

8. We recommend that the Ministry of Community and Social Services choose a standard Risk Assessment Tool to be used on a mandatory basis by all child welfare agencies in Ontario. This tool should be used by intake and family/child service workers to assist in

the identification of risk at the time the file is opened, when a new report or new information is received and as a device for ongoing case assessment. Data from the use of this tool should be collected and analyzed to determine the tool's effectiveness. A shortened version of this tool specifically designed for Intake purposes should be utilized to facilitate quick assessment of the risk factors involved. This could be used to timely assess the need for a court order or apprehension of children.

During the inquest an announcement was made by the Minister of Community and Social Services that a risk assessment tool would be used on a mandatory basis by all child welfare agencies. The Risk Assessment Tool should be used at intake, whenever a new report or new information is received and as a device for ongoing case assessment. Data should also be collected so that the tool can be evaluated for effectiveness.

9. We recommend that the Risk Assessment Tool selected by the Ministry of Community and Social Services include specific inquiry by the child welfare worker into juvenile fire-setting behaviour, particularly in cases of inadequately supervised pre-school children, as well as a structured home safety check where the parent(s) participate(s) with the worker in evaluating the safety (including fire safety) of the home.

The risk assessment tool selected by the Ministry of Community and Social Services is a standard risk assessment tool. It was the understanding of the jury that it does not include any specific inquiry into juvenile fire-setting behaviour especially in the case of inadequately supervised pre-school children. The risk assessment tool also does not require a structured home safety check. The expert in child psychiatry and juvenile fire-setters testified that juvenile fire-setting is a high risk in children who are neglected and inadequately supervised by the parents.

The jury is recommending that the risk assessment tool be modified to address the issue of juvenile fire-setting. Home safety checks should be required to ensure that smoke alarms are present and their mode of action is understood and to ensure that smoking supplies, lighters, matches are stored safely. Exits should be kept clear and the family should have and be familiar with a home escape plan in the event of fire. It is also important that any juvenile fire-setters identified in this process be referred immediately to Arson Prevention Programs for Children.

10. We recommend to the Ministry of Community and Social Services that they consider sharing appropriate information from its soon to be implemented interactive computer database with Police Services and the Office of the Coroner to assist them in carrying out their respective roles in child protection. We are frustrated with the existing system and levels of documentation. An automated solution should be put in place. This would meet the needs of the front line worker, the needs of the child welfare service delivery system and the needs of the Ministry for systems management.

The interactive database announced during the inquest by the Minister for Community and Social Services is a good start to assisting the ministry in assessing the numbers and types of these children in need of protection and the outcomes of any intervention. The jury heard evidence from the police and from the coroner's office that the sharing of

information with the police and with the Office of the Coroner would assist in ensuring that proper evaluation of these cases was done by these agencies in the case of children who come to the attention of the police or coroner.

11. We recommend to the Minister of Community and Social Services that she consider the internal structure of the Ministry and make changes that would ensure a clearer focus on the child protection system and the provision of support to the system. This could be facilitated by reinstating the Office of Director of Child Welfare.

The evidence of representatives from the Ontario Association of Children's Aid Society the Ministry of Community and Social Services about the internal structure of the Ministry made it clear that the Ministry is highly de-centralized and the focus and emphasis on child protection programs are variable from place to place. The logical conclusion that the jury drew is that the Ministry needs to ensure a clearer focus on the child protection system and the provision of support to that system. One way that this could be done is by re-instating an Office of Director of Child Welfare to ensure that there is some centralized point for assessing and coordinating and ensuring uniformity across the province for child protection programs.

2. Funding and Resources

Finding: ***Child Welfare agencies are in need of funding to support the critical component of our society - our children. Supervisors and all Family Services Workers are overloaded and unable to properly function with their current staffing levels. Resources such as intensive and structured intervention programs are almost non-existent. The low level of monitoring received by this particular family appeared to do more harm than good.***

1. We recommend that the Ministry of Community and Social Services in conjunction with the Ontario Association of Children's Aid Societies should develop and implement a funding formula for Children's Aid Societies which recognizes variations in the community's child population, social and economic factors and the workload of the local Children's Aid Society as mandated in Section 15, Subsection 3 of the Child and Family Services Act.

Testimony at the inquest from the executive directors of the Ontario Association of Children's Aid Societies, and of the Family and Children's Services of Waterloo Region, and from a representative of the Ministry of Community and Social Services was that Children's Aid Societies vary in the child population they serve due to social and economic factors and that the workload of different Children's Aid Societies can be quite variable. The funding formula that is currently in place does not recognize or reflect this variation accurately. A realistic funding formula should be introduced that recognizes the variations.

2. We recommend that the Ministry of Community and Social Services in conjunction with the Ontario Association of Children's Aid Societies establish workload standards for

the core child protection functions of Intake, Family Services, and services to children in care (including the recruitment and training of foster parents). The standards should state the maximum workload (not number of cases since the amount of work for each case varies) each social worker should manage at any one time, as well as the ratio of social work staff to each supervisor, and to administrative support staff. The standards should recognize the time required to fulfill accompanying training, administrative and accountability functions.

The standards that the Ministry develops should include workload standards for core child protection issues. These workload standards would assist the Ministry and the Children's Aid Societies in having a sensible and workable funding formula as well as assist each society in setting expectations for case investigation and management.

3. We recommend to the Local Children's Aid Societies where workload standards are exceeded, that a formal case be made to the Ministry of Community and Social Services for more funding to increase staff.

There was evidence at the inquest that the Children's Aid Society could apply to the Ministry for contingency funding for cases of abuse but that other cases of children in need of protection had to be managed from within the budget regardless of how many cases there were. This necessarily led to a significant reduction in the amount of resource that could be offered to protection cases that were not abuse related. The jury is suggesting that when this situation is recognized by local children's aid societies that they make a formal case with the Ministry of Community and Social Services for more funding either from the contingency fund or some other resource.

4. We recommend to the Ministry of Community and Social Services that requests for more funding to increase staff at the Local Children's Aid Society level be considered based on the workload standards. Should funding be unavailable to cover workload/staff requests, the Ministry should apply to the Ontario Legislature for additional funds.

This is a further comment on the issue of funding for child protection issues and addresses the fact that workload standards would assist Children's Aid Societies and the Ministry in assessing such requests. The jury was clearly unwilling to accept the funding limitations on the ministry even though they come from the legislature. They recommend that the ministry apply to the legislature for more funds if mandatory child protection investigations require such funds.

5. We recommend that the Ministry of Community and Social Services ensure that child welfare agencies are funded to include programs for early intervention and prevention of child protection issues, such as monitoring high risk families (teenage mothers, high risk neighbourhoods)

It was clear from the evidence from the inquest that monitoring high risk families is a prevention issue and does not necessarily constitute a protection issue in the first instance. Recent funding cuts from Children's Aid Societies with these programs for children in high risk families are being cut back and/or closed.

There was ample evidence at the inquest that Neglect is an insidious problem which leads to youth and adult dysfunction and continuing parental dysfunction in the next generation and that the only way to stop the cycle is to intervene in high risk families. The evidence was very persuasive that prevention programs should have a high priority.

6. We recommend that the Ministry of Community and Social Services provide funding for the programs which were originally intended to support the present Child and Family Services Act. In particular, studies have shown that chronic neglect needs to be addressed in the context of intensive and structured intervention programs e.g. Family Preservation, and we have received expert evidence to the effect that low level monitoring puts neglected children at greater risk of harm than no intervention at all.

The present Child and Family Services Act was enacted with the expectation that chronic Neglect cases would be offered an intensive and structured intervention program. However, the intervention programs were never introduced. We heard evidence from an expert in social work research, that lower level monitoring such as that received by the Dombroskie/Burns family may, in fact, put neglected children at greater risk than no intervention at all.

Witnesses to the chronic inadequate parental supervision and the chronic neglect of food and clothing requirements were frustrated because once the case was reported to the children's aid, there seemed to be nothing further they could do even though they saw no improvement.

7. We recommend that municipalities should retain some element of fiscal responsibility for child welfare, to maintain some local autonomy and flexibility. As of January 1, 1998 the Ministry of Community and Social Services will 100% fund Children's Aid Societies. We recommend to Regional Councils and municipalities that they continue to contribute funding as they have in the past, with the stipulation that these funds be used for prevention programs specifically aimed at alleviating Neglect.

There was evidence at the inquest that as of January 1, 1998, Children's Aid Societies will receive one hundred percent of their funding from the Ministry of Community and Social Services. Until that time, the funding formula will be eighty percent funding from the Ministry and twenty percent funding from the local municipality. There was evidence that local contributions encouraged interest and input from the municipality into the programs provided by the Children's Aid Society. Witnesses expressed the fear that one hundred percent funding by the Ministry will reduce the contribution of information and direction from the local municipality.

8. To the Local Children's Aid Societies we recommend that they keep the community aware of any new needs or deficits that arise, so that the community can determine the minimum standard it will tolerate and react accordingly.

The issue of the financial contribution that should be given to the problem of child protection rose again and again at this inquest.

9. We recommend to the Ontario Association of Children's Aid Societies and Local Children's Aid Societies the training and use of substitute case workers to alleviate situations of case overload, vacation, illness, leaves of absence and to enable them to meet training requirements. These substitute workers would gain valuable insights into Child Welfare issues and this would also serve as a vehicle for future permanent employment. These resources could be shared among the Provincial societies.

Evidence was heard at the inquest that during the case worker's absence for vacation and illness, community and police reports were investigated in an uneven, more superficial manner than usual and that substitute workers were often untrained completely in investigation and management techniques. This recommendation is meant to assist the Children's Aid Society in managing the obvious, regular problems of vacation, illness, leaves of absences and case overload by using trained substitute case workers.

3. Fire Prevention and Safety

A. Smoke Detectors

Finding: ***The smoke detector did not work and there was only one in the home. It was on the same circuit as the hall light and the circuit breaker was in the off position. It was never determined if the breaker was tripped by the fire, if the light had something to do with the failure of the circuit or whether it was manually placed into the off position. The landlord and tenant had never tested the smoke detector and the tenant had never been made aware of its location and operating instructions.***

1. We recommend that the Ontario Building Code be revised to stipulate that the power source for the smoke detector be on the same circuit as the refrigerator so that a loss of power would be immediately noted and repaired.

In the Dombroskie/Burns household, a hard wired smoke detector was present in the landing in the upstairs hall but it did not go off in this fire. The smoke detector was more than ten years old and that may have been the reason that it malfunctioned. However, there was evidence that the upstairs light also did not function. The upstairs hall light was not a very important electrical device in this home and it's malfunction was never investigated by the residents. The fire department in Kitchener suggested that if the smoke detectors were on the same circuit as the refrigerator, any loss of power in that circuit would be investigated by the home owner or home renter because it would be obvious to them that the refrigerator wasn't working.

2. We further recommend that the Ontario Fire Code be amended to meet the current Building Code standard as to number and location of smoke detectors. These can be either hard wired or battery operated smoke detectors or a combination.

The Ontario Building Code for new homes has a significantly higher standard as to number and location of smoke detectors than the Ontario Fire Code. This means that

homes built before the current building code was implemented are significantly less protected from fire. This recommendation is intended to address this.

3. We recommend that the Landlord and Tenant Act require the inspection of smoke detectors in rental dwellings to ensure that they are working properly and review the location and testing mechanisms with all new tenants and certify in writing that such checks have occurred. Written instructions for the maintenance and care of a smoke detector should be posted in every existing rental dwelling unit in a location where such instructions will be readily available.

When the mother rented the semi-detached house, she underwent a tour of inspection with the real estate agent. The tour of inspection did not include any discussion of the location or function of the smoke detector. The jury are recommending that the Landlord and Tenant Act require such inspection at the time of renting and that instructions for maintenance and care of the smoke detectors be posted so that the new tenant can be informed about the smoke detector that is installed in the residence.

4. We recommend that the Ontario Fire Code be amended to require written instructions for the maintenance and care of smoke detectors be posted in every rental dwelling unit in a location where such instructions will be readily available.

The explanation can be found in part 3.

5. To the Office of the Ontario Fire Marshall we recommend that the public be made aware that the average life expectancy of any smoke detector is 10 years and that these be replaced after this period of time. There should be a date of manufacture stamped on these devices. Batteries for conventional battery units should be changed when the clocks are changed to/from standard and daylight savings time. This should be promoted as a 'Smoke Alarm Test Day'. Promote the availability of different kinds of smoke detectors (ionization, photo-electric, sealed lithium batteries) and their applications and/or advantages.

Evidence was heard that the smoke detectors currently in use in Ontario have a life expectancy of about ten years. It was clear from the testimony at this inquest that this is not widely known and that there is no date of manufacture on a device so that a person buying or renting a house with a smoke detector already installed may have no idea how old the smoke detector is.

There was also evidence that conventional battery powered smoke detectors need to have their batteries changed about every six months and that this is frequently forgotten by home owners and home renters. If a public information program were mounted for 'Smoke Alarm Test Day' when the clocks are advanced and moved back for Daylight Saving Time, the public would be reminded to change their batteries every six months. Evidence at the inquest about the different kinds of smoke detectors was very interesting to the jury, none of whom had heard of these different types and their applications before. They are recommending that public education be done to ensure that the different applications be clear to the members of the public.

6. To the Office of the Fire Marshall, Local Fire Departments and Regional Councils we recommend a collaboration to make smoke detectors available and where necessary install smoke detectors free of charge in homes where it is unlikely that one will be installed by any other means.

The Dombroskie/Burns household was a household of poverty and chaos. It was apparent from the testimony from the family that routine home safety was not a primary concern of theirs. It seemed likely that if the smoke detector had not already been in the home they would not have installed one. I believe this recommendation is intended to ensure that homes in which the children are in need of protection be made special targets of the local fire department and the regional counsel so that free smoke detectors can be installed in these homes, especially where there is a possibility that there is a juvenile fire-setter.

7. To the Office of the Fire Marshall, we recommend that a battery backup of a single unit hard-wired smoke detectors be considered.

The smoke detector in the Dombroskie was a hard wired smoke detector and it did not function on the day of the fire. The reason for this malfunction was never discovered by the detailed investigation. The jury are proposing that a hard-wired battery have a battery backup to ensure that if there is a malfunction of a circuit that the smoke detector will still function.

B. Arson Prevention

Finding: ***The Waterloo Region Arson Prevention Program (WRAPP-C) is not well known within the community. It has had only a few referrals from Family and Children's Services and has had no response to its offer to make presentations to interested groups. The WRAPP-C program has been unable to develop an information exchange with the TAPP-C program. The WRAPP-C program differs from the TAPP-C program in the assessment of child fire setters. The research available through the Clarke Institute is funded in part by the Ontario Fire Marshall's Office.***

1. We recommend that the Office of the Ontario Fire Marshall and Local Fire Departments prepare information about this program and make it available to child welfare agencies, children's mental health providers, teachers, fire and police services and other members of the community.

Arson Prevention Programs evaluate juvenile fire-setters, ensure that there are home safety checks and make parents aware of the importance of constant vigilance and careful control of smoking and other ignition materials. The child welfare agencies, teachers and police services in Waterloo Region were unaware that there was an Arson Prevention Program in Waterloo. This recommendation is intended to improve this situation.

2. We recommend that child welfare professionals receive training regarding the links between preschool fire-setting behaviour and child protection issues.

Testimony at this inquest made it clear that child welfare professionals did not know there were links between pre-school fire-setting behaviour and child protection issues such as inadequate parental supervision. This recommendation is intended to ensure that this ignorance does not continue.

3. We recommend that the Ministry of Community and Social Services, the Ontario Association of Children's Aid Societies and Children's Aid agencies also develop links with the WRAPP-C/TAPP-C programs.

The Ministry of Community and Social Services and the Ontario Association of Children's Aid Societies and Children's Aid agencies also did not appear to be aware of the links between fire-setting and child protection issues such as inadequate parental supervision. Links with Arson Prevention Program should be forged between all of these agencies.

4. We recommend to the Office of the Ontario Fire Marshall and the Solicitor General that they encourage the exchange of information between the TAPP-C and WRAPP-C programs.

The TAPP-C and WRAPP-C programs differ in that the TAPP-C program has an emphasis on initial assessment by a children's mental health professional and immediate home safety check. The WRAPP-C program involves an assessment of the child by a fire service professional with no psychological or psychiatric training. The jury in comparing these two programs are obviously recommending that the two programs talk to each other and exchange information about their models.

5. We recommend that child fire-setters be interviewed for assessment screening by a children's mental health professional. A home safety check should be immediately provided for every case upon referral.

Please refer to the explanation for #4. The jury are recommending that the model used by TAPP-C be adopted by WRAPP-C and other local arson prevention programs that do not at present use children's mental health professionals to do the initial assessment of the child.

6. We recommend that the federal Hazardous Products legislation be amended to:
   - a) prohibit the sale, distribution or giving away of any ignition devices to persons under the age of eighteen
   - b) to require that ignition devices be kept behind the counter in retail stores
   - c) no minor may possess an ignition device unless the minor is under the supervision of an adult
   - d) require that child-resistant lighters be designed so that the lighter is rendered inoperable if the safety mechanism is removed
   - e) increase the visibility of warnings on disposable lighters (Larger print)

The Federal Hazardous Products legislation addresses the issue of child resistant lighters. The jury's amendments are largely self explanatory.
Explanation for part (d): It is possible to remove the safety mechanism from a child resistant lighter in order to make lighting the device easier. The jury would like to ensure that the child resistant mechanism is always maintained by having the device redesigned so that it will be inoperable if the safety device is removed.

7. We recommend that the Office of the Ontario Fire Marshall and other private sector entities such as insurance companies provide funding to ensure that Levels 2 through 4 of the 'Learn Not To Burn' program become available to all Canadian schools.

The 'Learn Not to Burn' program has been privately funded up to Level 1 and made available to Canadian schools. The jury is recommending that Levels 2 through 4 also receive funding and become available to all schools.

4. Emergency Services

Finding: ***The police were the first service dispatched when the nature of the emergency was as yet unknown. The discrepancy in time between the police and fire services caused some confusion when analyzing response times after the fact.***

1. To the Local 911 Dispatch Centre, the Regional Ambulance Services, the Police Services Board and the Office of the Ontario Fire Marshall we recommend that if there is not an immediate request for a specific emergency service that all services be dispatched.

The family dialed 911 when she saw a fire on the sofa in her living room. She was having difficulty breathing in the smoke so she opened the rear sliding door while the phone was ringing. This immediately caused the fire to flash over and her hair caught on fire so that the 911 operator only heard her screaming and did not know that there was a fire. The operator assumed that this was a case of domestic violence and dispatched the police. It was only when a neighbour telephoned to report the fire that the fire department was dispatched. The jury therefore recommends a tiered response so that there is no delay in the fire department being sent to a scene.

2. To the Regional Police Services, the Local Fire Departments and the Regional Ambulance Services we recommend that they synchronize their clocks on a regular basis.

Evidence was heard from the police, the fire department and the ambulance services that their clocks are not synchronized so an evaluation of the arrival time of the various agencies could not be done.

5. Education

Finding: **We find that with this particular family a role model to demonstrate appropriate life skills was unavailable. There was a need for essential parenting skills. Due to lack of supervision the children's safety was jeopardized. When it comes to safety matters and life skills, our**

education system remains as one of our most essential resources. In this case it was the only one.

1. We recommend to the Ministry of Education and Training that they provide appropriate funding and make it clear that schools should continue to teach students parenting and life skills in appropriate grade levels (senior elementary/junior secondary).

A number of principals and board officials expressed concern that the coming change in the curriculum at schools may reduce any funding to parenting and life skills programs. It was clear during this inquest that the mother would have benefited from parenting and life skills programs when she had been in school and that parenting and life skills programs may help to break the cycle of poverty and inadequate parental supervision which is currently a major problem in Ontario. The jury are clearly recommending that these programs be continued even when a new curriculum is in place.

2. We recommend that the new curriculum from the Ministry of Education continue to require safety education with specific outcome expectations at grades 3, 6, and 9. The outcome specified for the end of grade 3 should specify how to 'get out alive', and the dangers of playing with fire in the fire safety outcome exceptions. Teachers should make use of available tools such as the 'Learn Not to Burn' program.

Safety education with specific outcome expectations is also an area of concern for school board officials, teachers and principals because they feel that these programs may be discontinued with the new curriculum from the Ministry of Education. The jury agree with these officials that these programs are quite important and should be continued in the new curriculum.

3. We recommend that the Universities of Ontario which provide degrees in Social Work at the Bachelor and Master's levels foster a stronger research culture in child welfare programs and that continuing education programs utilizing research results be offered to social workers in present practice. We also suggest that courses be taught in investigative techniques, Neglect: Causes and Effects, substance abuse, domestic violence and the interviewing techniques of very young children.

There was testimony at the inquest from the expert in social work that there is no tradition of remaining up to date with literature and research in the field of social work. This recommendation is aimed at trying to improve that. It was apparent at this inquest for instance that none of the social workers were aware of the link between inadequate parental supervision and juvenile fire-setting behaviour although these were very important links in the causation of the deaths of these children.

The jury are also recommending that continuing education can be used as a mechanism for increasing social workers' awareness of new information in their field. Investigative techniques, the causes and effects of neglect, substance abuse, domestic violence and interviewing young children are also areas in which the education of social workers is

lacking. The jury clearly felt that they required education in these areas as well as training to improve their skills.

4. We recommend to the Ministry of Community and Social Services that they consider launching a public awareness campaign on Neglect to highlight the effects on children and the community. This should use all forms of the media. Public service announcements should be broadcast at a time when the target audience will be most likely to benefit.

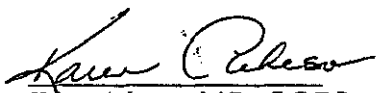
Community awareness about the importance of child neglect might assist in ensuring that cases of children in need of protection are appropriately reported to Children's Aid Societies and might make the community more supportive of increased funding to programs aimed at assisting children in need of protection.

5. We recommend to Health Canada that they re-establish their public awareness campaign concerning child-resistant lighters (Out of Sight, Out of Reach).

A representative of Health Canada testified that child resistant lighters are child resistant not child proof. They are designed so that a first accidental exposure of the child to the lighter will not result in instant success in lighting it, allowing a parent an opportunity to intervene. Normal children who are allowed to handle and play with lighters or who witness the use of lighters will be able to operate the lighter quite well. The testimony of the mother was that she believed that lighters were supposed to be child proof.

The public awareness campaign Out of Sight, Out of Reach was a good vehicle for informing parents about the hazards of lighters and what to do to prevent accidents.

In closing I would like to stress again that this explanation is written solely for the purpose of assisting the reader to understand the verdict. The comments that I have made are my recollections of the evidence and are not put forward as actual evidence. As in all inquests, a court reporter recorded the testimony of all witnesses, the summations of persons with standing and my charge to the jury. If any party wishes to refer to actual transcripts, the court reporter was Dana Moore, R.R.#3, Mildmay at 519-799-5405.



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